PRESCRIPTION NARCOTICS: THE MISUSE, OVERUSE, AND ABUSE

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DEDICATION

To

Shirley, Dennis and Family

ABSTRACT

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Master's of Medical Humanities

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In this paper, I look to address the increasing problem of the misuse and abuse of prescription drugs. I suggest that the rising abuse of narcotic medications is a tri-fold issue: 1.) an increase in the use of patient satisfaction surveys, 2.) inadequate or insufficient technologies accessible to physicians to help regulate the problem coupled with a lack of time to properly use said technologies, and 3. the business of pharma and the demands for profit. Is this phenomena caused by the big business, pharmaceutical companies, or a lackadaisical attitude toward the prescribing of said drugs? I suggest that neither is entirely to blame nor it is solely due to a lackadaisical attitude, but instead to the demand put on physicians to give the patient what they want and a lack of the

proper and adequate technologies to differentiate abusers and users. This problem coupled with the motivation and intentions of pharmaceuticals to make a profit leads to abuse, overuse, and prescription drug habits. Through my research I have found an alarming connection between patient satisfaction surveys and the abuse of narcotic medications. Patient satisfaction surveys are the latest tool to aid in providing "better" health care to patients through questions and answers; however, while they have their benefits, they are leading physicians to write prescriptions for narcotics simply to appease patients. For the physicians, I argue that in some instances, it is not solely due to a lackadaisical attitude on the physician's part, but instead to the demand on them to give the patient what they want in order to satisfy their patient satisfaction surveys. It is easier to write for these medications to appease patients, then dealing with a negative review and its repercussions. Physicians do not want to have to answer to bad patient satisfaction reviews, so they give into patient demands. The emergency room and care centers are becoming supermarkets for drug seekers. While I do believe that patient satisfactions surveys are beneficial, I believe they are turning the practice of medicine into a customer service oriented business controlled by supply and demand.

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LIST OF ILLUSTRATONS

PREFACE

Abuse of prescription drugs, particularly opiates and their close relatives, is a tri-fold issue sustained through patient satisfaction surveys, inadequate or insufficient technologies, and a solely profit-based mentality in the pharmaceutical industry and within hospital systems.

Thesis Statement: In this paper, I look to address the increasing problem of the misuse and abuse of prescription drugs. I suggest that the rising abuse of narcotic medications is a tri-fold issue. Its increasing prevalence is sustained through: 1) an increase in the use of patient satisfaction surveys, 2) inadequate or insufficient technologies accessible to physicians to help regulate the problem coupled with a lack of time to properly use said technologies, and 3) the morally questionable business practices of pharmaceutical companies and their demand for ever-increasing profits along with their dubious marketing and legal practices. It is undeniable that there is a rise in the misuse and abuse of narcotic prescription medications, which will inevitably continue if the aforementioned issues are not addressed.

Is this phenomenon caused by big-business pharmaceutical companies, or a lackadaisical attitude toward the prescribing of said drugs? I do not suggest that either pharma or physicians are entirely to blame. It is partially sustained through the demand on physicians to give the patient what they want and a lack of the proper and adequate technologies to differentiate between abusers and users; and partially the morality of the motivation and intentions of pharmaceutical companies to make a profit which leads to abuse, overuse, and prescription drug habits.

I assert this problem is generated and sustained by both parties involved and can only be corrected through the participation of both parties. I assert that neither is entirely to blame for the spike in the prescribing and abuse, but instead it is a compilation of multiple factors that involve pharmaceutical companies and physicians. The problem is a direct, yet unintentional, consequence of patient satisfaction surveys, a decline in the morality of prescribing these drugs (risk and benefit), and misleading marketing by pharmaceutical companies blurred by the necessity of making a profit. My argument regarding the two parties who are involved outside of patient satisfaction surveys is as follows:

1. Patients seek the help of physicians for narcotic scripts, legitimately or illegitimately for pain, and because of patient satisfaction, physicians are more willing to prescribe.
2. Some physicians are inadequately equipped to determine between drug seekers and those truly in pain. Because of this lack of diagnostic information it is easier to prescribe, which is fuelling the problem.
3. Pharmaceutical companies have created legal turmoil over the dispensing of narcotics by broadening the description of what type of pain they are to be used for, limiting generic competition, and marketing them to physicians who are not qualified to access the risk versus benefits to patients.

CHAPTER 1

INTRODUCTION

When discussing prescription drug abuse, I am specifically addressing the abuse of controlled substances, particularly pain medications—i.e. Vicodin and Percocet—within hospital or pain management centers. I will substantiate my claims regarding the emergency department's prescribing of these medications through collected data, which directly shows an increase in the dispensing of opiates through pharmacies.

The graph, below, represents a growing trend of the prescribing and dispensing of opioids over a nineteen-year span. The time frame, as shown in Figure 1 below, coincides with the time frame that patient satisfaction surveys evolved, and shows how patient surveys increased in popularity and usage over that same period. As empirically deduced from looking at this graph, the amount of prescribing and dispensing of the opiate class of drugs has risen significantly in a short amount of time. This is alarming given the severity of opioids, the high possibility of abuse and addiction, and the amount of overdoses and emergency room visits linked to them.

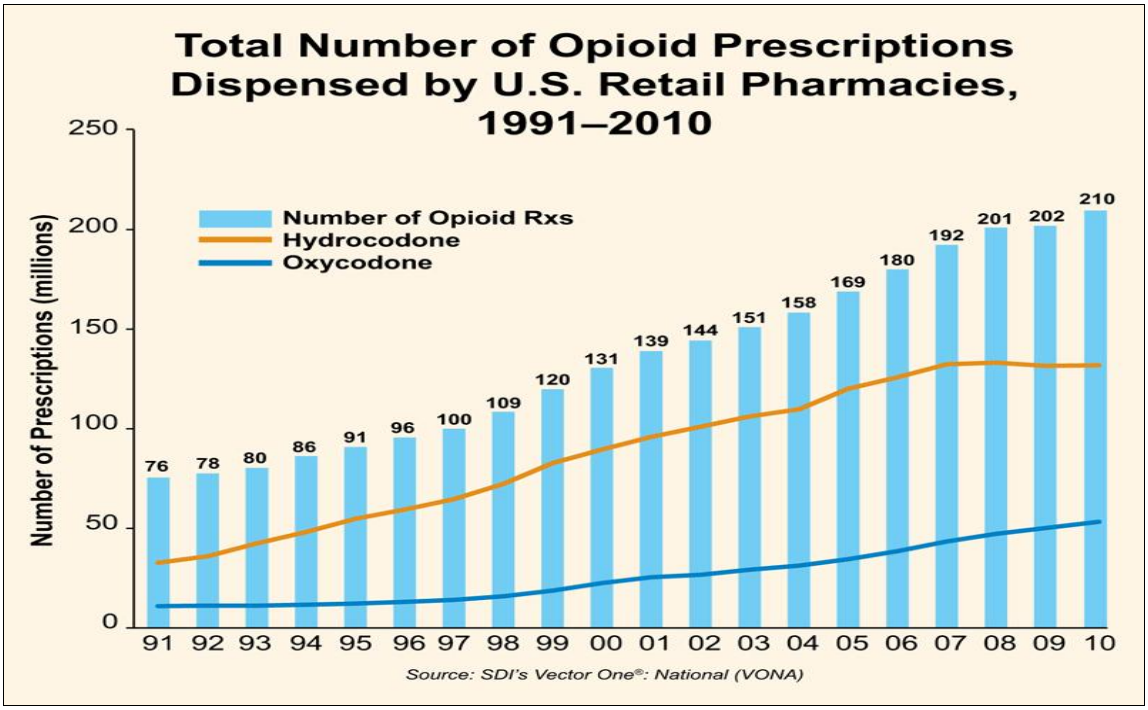

Figure 1. "Total Number of Opioid Prescriptions Dispensed by U.S. Retail Pharmacies, 1991-2010." Source. Volkow, Nora D. "Prescription Drugs: Abuse and Addiction." *NIH* 11 (2001): 1-15. National Institute of Health, Oct. 2011. Web.

CHAPTER 2

PRESCRIPTION DRUG ABUSE AND ADDICTION

Foremost in understanding the facts behind prescription drug abuse and how it is affects our society, Sharmila Devi's article "USA Homes In On Prescription Drug Abuse," does an excellent job of pointing out the alarming facts of the persisting drug epidemic.

According to the most recent data made available by the Centers for Disease Control and Prevention (CDC), deaths from overdose of painkillers rose from less than 4,000 in the year 2000 to more than 11,000 in 2007. By contrast, heroin deaths have remained steady at about 2,000 each year, and cocaine deaths rose from about 3,000 in 2000 to more than 5,000 in 2007. Thomas Frieden, director of the CDC states, "Unintentional drug overdose is a growing epidemic in the US, and is now the leading cause of injury death in 17 states"(Devi).

As we can deduce from this article, prescription drug abuse is becoming a largely escalated problem that is taking more lives than illicit drugs. From this we can also determine that it is occurring at a rather alarming rate in a short amount of time, particularly within the last decade or so.

Understanding why this is becoming a large escalating problem is to understand the root of the problem, and how all the other parties factor in and contribute to it. First, we must understand what drug addiction is and how it relates to prescription narcotics and abuse. Secondly, we must understand how these drugs affect the body and the person. Lastly, we must understand the cycle of abuse.

Prescription drug abuse is the consumption of a prescription not prescribed to you, using a prescribed medication improperly or other than prescribed, or using prescribed medications to obtain a high feeling rather than to relieve pain. Abuse can lead to addiction. Addiction is when a person becomes reliant on a substance to function and may experience symptoms of withdrawal without said substance (Volkow 1-15). Their addiction to the drug can create another personality, one that does not act the same while under the influence of the drug. They more than likely will deny any addiction and can easily become angered over discussing their addiction. The person needs to sustain their habit which can lead them into undesirable and dangerous situations. Whether they are relying on physicians to write scripts or buying the drugs off the street, they are continuously putting themselves at risk.

Some of the most common drugs that are abused are controlled substances and opioids which are prescribed to be used to help alleviate

pain by blocking the intensity of pain signals to the brain, affecting the part of the brain that deals with emotion, i.e. pain stimuli (Volkow 1-15). Some of these narcotic pain medications, under their generic names, include: codeine, oxycodone, hydrocodone, morphine, and others. These are commonly known by their brand names as Percocet or OxyContin (oxycodone) or Vicodin (hydrocodone). These medications are prescribed to treat varying levels of pain and sometimes even cough (codeine) or diarrhea (Lomotil).

CHAPTER 3

OPIATES: SCHEDULE, COMPOSITION, AND USE

Opiates, considered Schedule II or Schedule IV, are classified as controlled substances and can be naturally or synthetically derived. Many prescription opiates are synthetically derived in laboratories, and are created to have a similar composition and structure to natural opiates. Natural opiates are derived from the opium poppy plant. Both naturally occurring and synthetically derived opiates are classified under the larger title of opioids (ISATE). Opiates can be classified by three different names: opiates, opioids, and/or narcotics.[*] The term can also be used when discussing derivatives of opium such as codeine, morphine, and others. The term opioid is used to discuss this entire naturally or synthetically occurring class of drug (Addiction). One of the most commonly abused opioids is heroin. Heroin does not have any approved

[*] For the purpose of my paper I will use opiates, opioids, and narcotics frequently. While there is a distinction addressed previously, I will differentiate them as I feel appropriate for the context of the particular section. Overall, all the terms above refer to the same substances, natural or synthetic. I will use these terms also to refer to cousins, such as codeine and morphine, of this family of medications. The close cousins fall under the category of controlled substances that have a possibility of addiction to them and abuse of them.

medical uses within the United States and is considered a Schedule I drug.

It is alarming to think that this class of prescription drugs is synthetically derived to be chemically similar to a common opioid street drug which is known to cause many overdoses and deaths. It is hard to fathom that there is a negative connotation connected with heroin use, but its severity does not seem to translate to opiate medications; their misuse and overuse which leads to prescription drug abuse. It seems as though we view the use of a prescription opiate as acceptable because it is a regulated product, but unfortunately misuse and abuse of this substance can yield the same results for people as taking heroin.

Opioids have become one of the most prescribed classes of drug within the United States. Some opiates are classified as narcotic analgesics or narcotic pain medications. They can be used to treat varying levels of pain; from severe to moderate depending on the opiate prescribed. They are prescribed for their pain relieving, or analgesic, properties, which work by depressing the central nervous system. They work by attaching to specific opioid receptors that are found throughout the body—i.e. the brain, gastrointestinal tract, and the spinal cord—and when attached, they void the transmission of pain signals to the brain. These drugs can be linked with sleep apnea, reduced hormone

production, falls, and hip fractures in the elderly. Some people may not even be able to tolerate them; their use making the person sick. Some people experience an outer body experience form taking the opioid because it involves chemistry which affects the portion of the brain that deals with reward.

These substances can cause a euphoric effect because they attack the part of the brain that moderates pleasure. Because the pleasure part of the brain is being influenced it can cause a drowsy, yet comfortable feeling for the user. Given that it causes a euphoric experience, it becomes easy for people to abuse the drug which sets up the opportunity for an overdose and possibly death.

When opiates are used over time for pain relief, many users may become physically tolerant of the opiate which will require a larger dose to reach the same amount of comfort. In some users this euphoric feeling transcends into an addiction to the substance.

When someone becomes addicted to the substance, they can begin to obsess about it, fixating on how they will be able to obtain more. They may begin to doctor hop, seeking scripts from various physicians, or illegally purchase the substance to satisfy their addiction in order to create a better feeling by intensifying the euphoria the opioid gave. They will even take it in ways other than prescribed. For example, OxyContin

is formulated to release pain management over an extended time; however, people that look for that instant gratifying high do not want to wait for the slow release. In order to obtain this instant high, instead of taking the medication orally, they will snort or inject the medication. This can be very dangerous and lead to overdose and death.

Opioids facilitate a relaxed detachment from pain and desire, which in turn can reduce feelings of anxiety and stress (ISATE). “Opioids also tend to produce drowsiness, reduce heart rate, cause constipation, cause a widening of blood vessels, and depress coughing and breathing reflexes” (ISATE). Because opiates reduce the heart rate and depress breathing if taken in excess, many times people who abuse these substances go into cardiac or respiratory distress, which causes death, because they are looking for that “higher high” or euphoric effect. Many accidentally overdose because they take too much, in an attempt to get that high. Given the nature of the drug, the body becomes more tolerant of the euphoric effect faster than it does to the dangerous effect of the drug. The more of the substance you take, the higher the euphoric feeling as well as an increase in the dangerous effect it has on the body. The body has prepared itself for the euphoric effect through tolerance, but is not yet tolerant to those levels of the dangerous effects, such as

depressed respiration and a reduced heart rate. The dangerous effects are what generally lead to accidental overdoses.

Narcotics and opiates are considered controlled or scheduled drugs for a good reason; they have an increased abuse risk or potential for abuse. The Federal Drug Enforcement Administration assigns drugs to schedules that range from one to five. Schedule I drugs (mainly illicit drugs, not approved within the United States for medical treatment) are considered the greatest risk and carry the highest potential for abuse; Schedule V drugs are considered the lowest risk or potential for abuse. An example of a Schedule I drug is heroin and a Schedule V drug would be used to treat or stabilize everyday ailments or illness, such as blood pressure or diabetes.

Narcotics are considered either Schedule II or Schedule IV drugs. Not all Schedule IV drugs are considered narcotics; Schedule IV is comprised of small amounts of non-narcotic and narcotic medications. Schedule II drugs have a high risk for abuse, but are deemed safe for medical treatments within the United States. These drugs have the potential to cause physical dependency (Controlled Drugs). Some examples of Schedule II drugs include: Percocet, Hydromorphone, OxyContin, Opana, and others. Schedule IV drugs are considered less of a risk for abuse than Schedule II drugs, but they can still be addictive.

They are also used in safe and accepted medical treatments within the United States. Some examples of Schedule IV drugs include: Tylenol #3, Vicodin, Vicoprofen, Norco, etc.

People who abuse narcotics can face various health and socially related consequences that can lead to further drug misuse, abuse, and even death. If used properly, opioids can offer pain relief to the patient, but it is when they are misused that they can cause death. Opioids, as discussed above, work on the central nervous system and hinder the very basic life enabling involuntary events such as breathing, blood circulation, and oxygen. If these basic functions fail because they are being acted on by a substance, death will ensue without medical attention. The solution then follows that if opioids are properly prescribed and monitored over the short term then addiction should not ensue.

Long-term use and misuse can create a physical dependence, which is common with long exposure to the drug or opioid. One problem that arises with dependence is tolerance which is where the beginning of the problem starts. Tolerance is when a patient becomes tolerant—or unrelieved of the pain—of a certain strength and may require higher doses to have the same effect. It can be hard for a physician to access if a patient is becoming tolerant to a specific strength of medication, or if

they are developing a drug problem. Dr. Ballantyne of the University of Washington medical school believes that, “If doctor’s understood how hard it is to get patients off these drugs, they would not prescribe them to begin with” (Meier, *Tightening*).

This physical dependence and tolerance coupled together can lead to addiction. Physical dependence is a normal adaptation to being exposed to a substance over an extended period of time. Physical dependence, however, is not the same as addiction. Addiction is characterized by the habitual seeking of a substance and the use of that substance even with negative consequences. Addiction, which can include physical dependence, is about the compulsive seeking of the substance. It does not matter how they get the substance at this point as long as they can get it. Patient’s can begin to develop habits to get the desired substance that are unsafe and illegal—buying them off the street, moving onto other illegal opioid related substances, or seeking out many doctors who will fill their prescription.

This behavior not only causes health retardation for the abuser, but creates a social retardation as well. Soon the habitual seeking of the substance consumes their life and becomes essentially what they live for; another fix. Family, friends, and responsibilities may be kept distant or ignored initially and throughout the process. The patient becomes so

consumed in the seeking behavior that they miss out on much of their life and other's around them. In a sense the seeker is stuck in the mentality where they developed the habit and are not able to mature beyond that point.

As discussed above, the problem of physician hoping can be somewhat monitored through pharmacies and insurance companies, however, many seekers will offer to pay cash or fill prescriptions in different states, making the tracking harder or impossible. Many seekers will lie and create ruses to make their need for the drug believable to get the scripts, and once those are obtained, they will do their best to make sure they are filled. They will find ways to limit the disruption of their mission, which is to support and sustain their drug habit.

A patient who is physically dependent on a substance can be susceptible to withdrawal symptoms when the substance is reduced or eliminated. Because the drug acts on the nervous system, the withdrawal effects can include anxiety, insomnia, irritability, and low energy (Addiction). Other withdrawal effects can include allergy like symptoms (runny nose and teary eyes), and periods of sweating, goose bumps, muscle aches and pains, cramping, nausea, vomiting, and diarrhea (Addiction). Withdrawal from opiates is not necessarily something life threatening, but can be if they are coupled with a comorbidity, or when

in combination with other substances. If a person is properly weaned off the medication, and if addiction is adequately diagnosed, then withdrawal symptoms can lessened through proper treatment. Two mechanisms in which withdrawal symptoms can often be managed or even avoided is through a physician or by drug tapering medications.

High level pain medications, opiates, can be safely used when the usage is monitored and prescribed correctly, but can be very detrimental to a patient when they are misused. I will utilize information collected from the CDC, to show how a good thing can become a very devastating thing if used improperly.

As reported by the Centers for Disease Control, over-prescribing, abuse, and misuse are problems coupled within each other. They substantiate their claims with statistics which include facts such as: For every *one* overdose there is "32 emergency department visits for misuse or abuse, and 130 who abuse or are dependent"; emergency room visits for painkiller abuse or misuse has doubled within the past five years to nearly one-half million, twelve million people admitted to using pain medications for recreational purpose, and the recreational use of narcotics costs more than $72.5 billion in direct healthcare costs. In 2010, enough painkillers were prescribed to medicate every adult in America, around the clock, for one month (CDC).

According to the National Institute on Drug Abuse, roughly 52 million people have admitted to using prescription medications recreationally, and of that group teenagers make up a large portion. According to a Monitoring the Future survey done in 2010, one out of every twelve high school students admitted to non-medical use of Vicodin, and one in twenty admitted to using OxyContin for recreational purposes, which makes these two of the most common drugs that are abused.

This becomes the foundation of the growing problem because it is reaching young, impressionable people whose use will likely transcend into an addiction. It is alarming because they do not realize what they are exposing themselves and their bodies to while they are still developing. In the course of addiction, if an addiction ensues, then the addict will remain at that young and naïve age with an increasing addiction. The underlying question that needs to be addressed is how are they getting these substances? We have become so lackadaisical about narcotic medications that we make it easy for anyone to have access. This is probably why we have recently seen an increase in the amount of commercials regarding prescription drug abuse and those who have access to these prescriptions.

Because of the demand, there has been a drastic increase in the prescribing and dispensing of these drugs in most recent years to fill the supply. Within our society, we have become perpetually more willing to take a pill to fix an ailment. We assume these medications are less harmful than illicit drugs, but they may not be. These medications can be just as or even more dangerous and addictive than illicit drugs. Taking a pill is faster, easier, and less of a time commitment than going through physical therapy, etc. and is more readily paid for by insurers because it is less expensive for them.

The overall impression I deduce from this is that it is cheaper and easier to create a drug laden and dependent society. We look for a quick fix to our ailments and are under the impression they are safer drugs, thus we have become more open to being a narcotic laden society that is becoming increasingly addicted. The underlying problem is that no one is really addressing or stopping this behavior, instead it is being supported and accepted through the writing of more and more scripts. Pharma, physicians, healthcare systems, and insurers are all equally culpable to the underlying cause and problem. The inability to control the problem has led to the number of unintentional overdoses—due to narcotic pain medications—to quadruple between 1999 to 2007. Narcotics have caused more unintentional overdoses than heroin and cocaine combined (Volkow

1-15). It is more comforting to believe that it is easier to take a pill which is prescribed because it is safer; however, they have been shown to cause more overdoses than illicit drugs.

One of the problems that people with prescription drug addictions discuss is how it is more accepted in a particular given society. More rural areas are laced with prescription drug abuse, whereas in more industrial cities it may be less common. Essentially, society is permitting this behavior because it has become socially acceptable within certain areas. It is more socially accepted because it is a regulated and FDA approved drug versus its street counterparts such as heroin. Part of the issue is not only social acceptability, but also the increasing amount of people who are receiving these medications. Many people who receive these prescriptions are those who receive disability benefits; those who receive disability due to chronic pain. If we allow this to continue; we are supporting the idea that chronic pain can only be treated with heavy narcotics, and that it is permissible to keep people “doped” up on these substances. This can quickly spiral out of control if their pain and claims are not monitored, and the acceptable care is an increase in the amounts of narcotics given. It is almost as though society permits and supports this way of thinking and the behavior associated with it.

A more recent unveiling of the increasing problem of prescription narcotic misuse and abuse were brought to light when multiple recipients of worker's compensation claims were dying. The trend started in 2006, when the alarming rate of 32 people, all receiving worker's compensation and were prescribed opioid pain medication, died due to an overdose of the medications. It was found that within a few years the average daily dose of the worker's compensation recipients had risen by fifty percent and the number of receivers was in the thousands. What was happening? Physicians were not monitoring the pain to see whether it was improving, instead they just kept prescribing more and more at higher strengths (Meier, *Tightening*). Physicians kept prescribing higher doses for these patients because they had become tolerant of the doses they were given. Once a patient becomes tolerant of a substance, he or she requires more of the drug in order to reach the same amount of pain relief as previously experienced.

While it is medically acceptable to increase the dose; it should be done only after accessing the patient's pain level and gauging whether it is improving. Negligence was the downfall in the case of the worker's compensation recipients because their pain was not being monitored; they were just receiving increased doses. The case of the workers compensation beneficiaries' shows how prescription drug abuse is

sustained and enabled when pain levels and improvement is not monitored in patients who are consistently being prescribed narcotic pain medications.

Another reasonable example of the negative effect when physicians do not monitor the pain level of a patient, but just increase their dose(s), happened to a nurse. The case of Nurse Mary Crossman is just one example of many of physician negligence regarding the use of narcotics for pain management. Crossman was diagnosed with lupus, an autoimmune disease that can cause joint and muscle pain. As a treatment for her lupus, her physician prescribed her OxyContin and methadone, two heavy painkillers. The physician routinely increased the doses that Crossman was taking when she became tolerant of the lower doses. Five years after she began the sustained treatment, she visited another physician and recalls the physician saying that given the high doses of heavy narcotics she was on; the doctor did not want to see her die (Meier, *Tightening*). The prescribing physician had increased the prescription levels to a point that was beyond dangerous to Crossman's health. This is a misuse of the substance and can lead the patient to an addiction or death. This could have been the circumstance of Nurse Crossman had her new physician not been alarmed by the high dosages of prescriptive narcotics she was taking.

Dr. Portenoy of Beth Israel Medical Center as well as other pain specialists say it is acceptable to increase the dose of pain medications in patients as long as the patient's pain is being monitored and is showing improvement (Meier, *Tightening*). Unfortunately, it is more common for physicians to simply increase the dose rather than monitor the pain especially in those individuals who, along with pain, may experience depression or anxiety. This can create situations of comorbidity. It becomes about stabilizing the person's pain and psyche rather than focusing on the underlying condition. The underlying condition being why the person is in pain and if there are other ways or supplemental treatments in an attempt to decrease the amounts of opiates or high levels he or she is on.

The lack of adequate monitoring along with physicians being script happy is part of the misuse component that can lead to abuse in the increasing prescription narcotic abuse epidemic. Misuse is not only relevant in the patient arena, but is applicable to physicians as well. The whole issue is comprised of a lack of responsibility of the system and in the end only the patients truly suffer. The misuse of narcotics as defined above is leading to abuse. The answer of how to address the problem seems very simple—by monitoring pain levels and being mindful of how many scripts are being written—but many factors muddle the simplicity

of the solution. Some of these factors include: patient satisfaction surveys, demands on physicians and their time, and the profit-based mentality of hospitals and pharmaceutical companies.

CHAPTER 4

PATIENT SATISFACTION SURVEYS

Patients seek the help of physicians for narcotic scripts, whether for legitimate or illegitimate pain, and because of favorable ratings from patients on their satisfaction surveys, physicians are more willing to prescribe.

Throughout my research, I have found an alarming connection between patient satisfaction surveys and the increase in the abuse of narcotic medications. Patient satisfaction surveys are the latest tool to aid in providing “better” healthcare to patients through a question and answer based assessment. While there is no denying they have their benefits, they are also creating negative consequences which are leading physicians to script for narcotics simply to appease patients. First, I will look at patient satisfaction surveys or Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys which more recently have become an increasingly important facet of medicine and its practice (CMS). A patient satisfaction survey is a questionnaire given to patients regarding their opinion of the services rendered (US Dept. of Health). They are a way for healthcare facilities to compare themselves to

other facilities and a tool to help standardize what is expected of healthcare facilities. While patient satisfaction surveys have been around for many years; recently there has been an increase in the importance of them regarding how a patient feels leaving the hospital, and how this affects the hospitals reimbursement. What was once a tool used to help improve the care that one is provided and to learn from people's experiences, now is turning medicine into a customer service oriented business.

While I think they are beneficial, unfortunately they are also detrimental to the dignity of physicians and the professionalism of medicine. Physicians are pressured into appeasing patients who come into the emergency room complaining of pain. Instead of being allowed to use their professional judgment in assessing whether the pain is legitimate or the patient is seeking narcotics, physicians must appease, because appeasing makes the situation easier for both the physician and the patient. Physicians would rather prescribe, then to have to deal with a bad survey or the repercussions of saying "no" to a patient. Medicine has been pushed out of a profession and into a business oriented realm, which allows for the abuse of prescription drugs to spiral out of control.

I will discuss in more detail how physicians feel regarding patient satisfaction surveys and narcotic medications later in this paper. This

section is primarily to discuss what the survey is, why it is implemented, and how I believe it is partially sustaining the increasing problem of prescription drug abuse.

I briefly discussed what the satisfaction survey is, why it has been implemented, and its focus to make healthcare better through patient feedback. Surveys are beneficial in that a facility can compare itself to similar businesses as a way to improve. The answers are beneficial because it can help standardize healthcare and make patients anywhere experience all that it can be. By this I mean that a patient can feel comfortable in going to any hospital and feel like they are getting adequate care without worrying whether one hospital is better than another. These surveys are a definite and effective way to help clear healthcare practice issues. On the flip side, they also can put hospitals and physicians in challenging situations. Because the surveys can affect reimbursement amounts, a hospital never wants a negative review. Hospitals will do whatever is in their power to make sure that they do not get a negative review. In the end, the hospitals need to be reimbursed for services rendered because it needs to remain open for business.

It is undeniable that hospitals are businesses which require income for services rendered. However, this business mentality is undermining the professionalism of medicine. The business mentality is

opening the door for an abuse of the system that is rooted in the fact that hospitals need to have money coming in to support the money going out. The money going in must be at least equal to or greater than what is going out or the hospital will fail. It has the potential to put physicians between a rock and a hard place regarding prescribing controlled substances. They may have to put aside what they feel is right in order to avoid being reprimanded later for their decisions regarding the prescribing of an opiate class of drugs. If the hospital receives a poor patient satisfaction survey, they may not be reimbursed completely or to the extent necessary to maintain the income to export ratio. Thus, they need favorable patient satisfaction. This means that in order for the hospital to get satisfaction, all the patient's needs must be met, even if it is against the better judgment of the physician.

Unfortunately, if a patient is not satisfied with the care he or she has received due to dissatisfaction with a physician; then the physician must answer to their superiors regarding the issue. The surveys are randomly administered and need to be done on a monthly basis (CMS). Because it is never known who will receive them, it forces physicians and healthcare providers to appease every patient or potentially face the ramifications of a bad survey. Essentially, this forces physicians to write scripts whether they feel it is appropriate or not. I assert that this is why

there has been a large scale increase in the amount of narcotic prescriptions written and dispensed. If a patient is not satisfied with the answer of one physician, then can move on to the next one until they receive what they want. With this new agenda, I feel hard pressed to believe that a physician would say "no" to a patient, because prescribing is easier and takes less time. If physicians *are* doing this, then it is making it easy for seekers to move from one doctor to another to get multiple narcotic scripts, enabling them to abuse drugs and become addicted.

Similarly, the increasing knowledge, awareness, and importance of these surveys are becoming more readily available to the public, making it easier for seekers to work the system to their advantage. In some ways these surveys are making healthcare professionals turn a blind eye to the manipulative behaviors of seekers which enable the seekers to sustain their addiction.

These surveys can make or break careers and they are forcing physicians to appease patients. A good example of how physicians simply appease the problem is discussed in testimony given by Dr. Benzoni, "If you're going to criticize me for not giving out narcotics, and you never praise me for correctly identifying a drug-seeker, then I'm going to give out narcotics" (Saint Louis 1) A key note here is that this is testimony by

a physician in regard to the surveys and the writing of narcotic scripts. It is alarming to be told from a physician that this is how they feel about what is going on, and how they respond to the situation. Dr. Benzoni is often criticized by patient satisfaction surveys and is asked by upper management to explain a bad review.

In this testimony we can understand why physicians write scripts so freely because it is becoming a lose-lose situation for them. They are criticized if they do write a script, and they are criticized if they do not. They choose the least resistant battle which is to write scripts for narcotics. Unfortunately, this is a poor predicament, because they know the effects that narcotic medication and addiction can have on that patient; yet, this knowledge is undermined by the easier alternative.

As I stated previously, deciding the wrong way in this predicament could cost a physician his or her job. It is unfortunate that the physician is the one who has spent many years in medical school and passed the boards to become the one who diagnoses and prescribes; yet, his or her knowledge and judgment is being undermined by the patients and administrators, each of whom has a specific agenda, which directly affects the physician. In other words, the patients are now able to self-diagnose and demand drugs from physicians; and the administration is

telling the physician what should and or should not be done in order to ensure business profits.

While patients may not be fully aware of the extent their influence can have on medicine and hospitals, physicians do. The survey gives the patient power and reduces the authority of the physician. While patient satisfaction surveys have a good intention in increasing quality patient care, one can see how it creates a slippery slope for physicians who are writing scripts for narcotics. Emergency rooms and care centers are becoming supermarkets for drug seekers. It has become equivalent to going in and saying “I feel like getting Vicodin,” or “Oh, you are writing a script for Vicodin? I was really hoping for Percocet today! Nope, I think I prefer Percocet, write for that.” While I do acknowledge that patient satisfaction surveys have their benefits, I also believe they are lessening the practice of medicine to a customer service oriented business controlled by supply and demand.

CHAPTER 5

CHANGES IN HEALTHCARE COUPLED WITH PATIENT SATISFACTION SURVEYS ARE PRESSURING PHYSICIANS

1. Patients seek the help of physicians for narcotic scripts for legitimate or illegitimate pain and, because of the importance put on patient satisfaction physicians are more willing to prescribe.
2. Some physicians are inadequately equipped to determine whether their patients are drug seekers or are truly in pain and, because of this it is easier to prescribe which is fuelling the problem.

For the physicians, I argue that in some instances, it is not solely due to a lax attitude on the physician's part, but the demand for them to give the patient what they want in order to satisfy the patient's expectations. It is easier to write for these medications to appease patients, then dealing with a negative review and its repercussions. Physicians, especially those in the emergency department, often lack the necessary technologies to accurately diagnose the pain, especially in

patients complaining of dental pain. While I sympathize with physicians put in this dilemma, I also believe that if a physician is prescribing this class of drug, they should be cautious and conscientious of the potential for abuse and overuse. They should be responsible with regard to their prescribing and make the best effort to help lessen the epidemic, not aid it. “There’s a huge amount of abuse of these medications, all over the country, and it starts with someone, somewhere writing a prescription” (Devi 378).

In the end it is that particular physician’s license, credentials, and reputation that will be questioned, not the hospital, nor the patient. They would not want to have their license revoked for being a questionable doctor, nor would they want to have a reputation as a doctor who will satisfy the needs of drug seekers. Though, I can only speculate that this is the case.

While health care and physicians are not entirely to blame for the increase in opioid over use and abuse, they contribute to a significant portion of the problem. The changes and demands of health care are forcing some physicians to write prescriptions for narcotics simply to appease the patient and to get them out of the emergency room as quickly as they can. This theory is supported by a quote given by Dr. Nathanial Katz, the director of the nonprofit Program on Opioid Risk

Management, “If your goal is to get people out of the emergency room, it’s about stabilizing and shipping out. What’s the easiest way to get patients shipped out? Write them a prescription for Vicodin. How long does that take?” (Saint Louis). When did feeding addictions and misusing heavy pain medications become a reasonable mentality to have? At what point did this become an acceptable solution? This is never a good mentality to have when addressing patients who may be seeking narcotics. Unfortunately, given the constraints of health care, physicians are made to believe that the easiest approach is the most effective in dealing with patients in pain. It is documented that physicians have been made aware of the high alert regarding the potential for abuse, especially among teenagers, regarding powerful pain medications and, yet, they are still being prescribed at an alarming rate.

As previously discussed, a huge part of the increasing problem comes from the pressures of patient satisfaction surveys, which are on the rise in the healthcare realm. They can make or break careers, and they are forcing physicians to appease their patients, which can lead to drug abuse and addiction.

I think the quote above is sufficient to the explanation of my next section about patient satisfaction surveys. Testimony given by Dr. Benzoni, “If you’re going to criticize me for not giving out narcotics, and

you never praise me for correctly identifying a drug-seeker, then I'm going to give out narcotics"(Saint Louis). This statement is exactly the reason why physicians just keep writing prescripts without asking questions. They feel pressured to write and are inadequately praised when they try to help the situation. Everyone would rather take the easier path and not the road less traveled because it is easy and established. Easy, however, has led to the misuse and abuse of opiates, allowing them to spiral out of control, and now we have made it very difficult to rectify the problem. It's easy to put it a bandage over it as has been done; however, the problem will keep escalating until physicians start making the hard decisions that attack the root of the problem. While the best fix for the problem seems to be that physicians need to say no; it is easier said than done because health care has bridled and saddled the issue.

It is understandable why physicians look to appease patients rather than providing explanations for why a patient was not satisfied with the care they provided. Either way physicians are put in a slippery situation because they can be at fault for not treating a patient's pain whether it's legitimate or a scheme to get a prized script.

Another component that factors into the demand on physicians is the time constraints placed on them, leaving physicians with little or no

options when it comes to writing narcotic prescriptions. With a high volume in physicians' offices and time restraints of insurance providers, physicians are often forced into writing scripts that may be for drug seeking purposes alone. For example, there is a system in place in forty states and eight of which have enacted legislation to create them. The system is a web site that the physician can log into to see whether a patient has recently been scripted for pain medications. Unfortunately, given time constraints and the demand on physicians many do not check the database. This is especially true in the case of emergency room visits. The bigger disappointment about this monitoring system is that many physicians do not realize the importance of checking to see whether a patient has been emergency room hopping to get narcotics. Either physicians do not have the time or realize the importance of looking up the patient which allows for drug seekers to go to multiple emergency rooms and acquire multiple narcotic scripts.

Inadequate technologies in the emergency room also can lead to misuse and abuse. One of the most common complaints in the emergency room is for dental pain. Spanning a ten year period (1997-2007), painkillers were prescribed in seventy-five percent of emergency room visits in which the patient complained of dental pain. Over the time period the number of dental patients in the emergency rooms rose

twenty-six percent (Saint Louis). Emergency room physicians are not properly trained to deal with dental pain to provide definite care, therefore, the easiest way is to treat the patient with medications. Without the proper x-ray machines and training, physicians are not prepared to access the pain to see whether it truly exists. I suggest that this is somewhat of a misuse of the substance when the pain cannot be substantiated. This causes a problem because if it is known that emergency room physicians cannot properly diagnose dental pain and just write for pain medications; drug seekers begin to feed on the ER's shortcomings and go straight to them for their narcotics. Many of the seekers will add that they are allergic to everything except Vicodin. This substantiates my earlier claim that emergency rooms are becoming like supermarkets where the patient (customer) decides what they want before they even go in.

This permits attacks on physicians who are in a vulnerable state and allows drug seekers to manipulate the system to feed their habits. It puts physicians in an awkward situation because it is hard to access who is truly in pain and who is just trying to get a fix. Unfortunately, for every one person who is truly in pain, you have two more whose primary purpose there is to obtain narcotic scripts. How does a physician know who is actually in pain and who is just there for the script? Since there is

no way to accurately diagnose, physicians simply appease patients with scripts for Vicodin.

On the other hand, sometimes in an attempt to satisfy their patients, physicians will overprescribe and write multiple narcotic scripts. When the physician is willingly writing them, then fortunately another tool can be utilized to curve the physician's mistake. Insurance, particularly prescription insurance, is a tool that can play an active and important role in curbing potential drug seekers. One of the biggest red flags I have personally experienced in my work as a pharmacy technician is when the patient says they will pay cash. Sometimes they have insurance on file, and you get a rejection of "refill too soon" because they had the same script filled at another pharmacy the day before. It brings the anomaly to the pharmacist's attention who then denies the patient the narcotic and puts a warning in the insurance profile that states the patient may be seeking narcotic fills daily. The pharmacist then calls other local pharmacies about the script. This method alerts us to physicians who are writing multiple narcotic scripts for the same patient consecutively. In this circumstance, the physician is at fault because they are writing multiple scripts consecutively for the same narcotic drug, for the same person. In this instance they have taken patient satisfaction too far and too literally. This information can help to figure

out who the drug seekers are, and who the doctor is that is “appeasing” their patient’s habit or trade. All of this information can be relayed to the insurance office and they can begin to monitor the physician and take necessary steps to helping alleviate narcotic misuse and abuse.

The aforementioned discussion is why physicians are responsible, culpable, and accountable for the narcotic abuse problem. While the demands of health care and patient satisfaction are high, I believe physicians should focus on the reason why they became a physician to guide their decisions. The bottom line is that physicians who just write for the narcotics are aiding and abetting abusers in dangerous and illegal behaviors, sustaining and enabling abusers/addicts is irresponsible and very dangerous. It is helping those who sell narcotics to get scripts, which is opening up the problem to more people—as mentioned before, the adverse effect it is having on teenagers—who are not educated about the severity of taking and abusing narcotics. It is irresponsible to give in to patient demands; the patient did not go to medical school or go through rigorous training to diagnose and prescribe, which is why they need a physician. If they are not qualified to diagnose themselves, then they really should not be demanding what is to be prescribed.

Another red flag signaling there is a problem is when a patient says they are allergic to everything except Vicodin, which makes one wonder

how many of these people are just given a script and sent on their way. Physicians should be better educated on how to deal with patients who are clearly there for the narcotics, and they should be supported by their employer, not scolded. Again, this trickles down to a business based on patient satisfaction; however, if patient satisfaction means supplying their drug addiction or allowing them to make a profit dealing to other vulnerable people, then there is a much larger issue at stake.

CHAPTER 6

PRESSURES ON PHYSICIANS AND DEMANDS ON THEIR TIME

Not only are physicians pressured to write for narcotics, but they are being placed under other extenuating pressures. Physicians are pressed for time, which is making it difficult for them to use some of the technologies available to help curtail and control misuse and abuse of narcotics. Some technologies are not available to physicians that would help them accurately diagnose certain types of pain that may require narcotics to ease or alleviate them. For example, physicians in the emergency department do not have the proper technologies to validate dental pain; yet, many people go to the emergency room to get pain medications for dental pain. If you cannot properly diagnose and validate pain, then who is to say they are not being fooled into writing narcotics scripts for someone's personal use?

One way I believe physicians can help is to limit the length of time of the supply they are writing for. If it is an emergency, then normally the appropriate physician will be able to see the patient within the time allotted before the prescription runs out. For example, if the script is

dental pain then a dentist normally would be able to see the patient within a reasonable amount of time. This would not require a large amount of pain medication if the physician decided to write for it in the emergency department. If a few days worth is given, then the physician can feel that he satisfied the patient's needs as well as prescribed a reasonable amount of medication to be taken over a short time. This would satisfy the patient satisfaction survey component and gives the patient a very limited quantity. Hopefully, the patient was legitimate and they will follow up with the dentist to address the problem.

While I sympathize with physicians put into this dilemma, I also believe that if a physician is prescribing this class of drug, they should be cautious and conscientious of the potential for abuse and overuse. Physicians should be responsible with regard to prescribing and make their best effort to help curb the epidemic, not aid it. They should be the whistleblowers of the situation, not the enablers of drug habits. Physicians know the effects of the drugs they prescribe and the potential of those drugs for abuse, so they should not enable the situation, but should be at the forefront protecting the patient. After all, is that not why physicians became physicians—to help keep their patients healthy and to do no harm?

CHAPTER 7

PHARMACEUTICAL COMPANIES INVOLVEMENT

Pharmaceutical companies have created legal turmoil over the dispensing of narcotics by broadening the type of pain their drugs are used for, limiting generic competition, and marketing their drugs to physicians who are not qualified to access the risk or benefits of the new drugs for their patients.

As for the pharmaceutical companies, I argue that sometimes profit outweighs the morality of why they should be doing what they are doing regarding tamper-proofing medications. Pharmaceutical companies' goals should be to help patients (after all that is why they produce regulated and approved medications) and not set them up for risk. While it takes much time and effort to get a new drug to market; profit and financial ties should not be the only guiding factors when marketing the drug.

Pros and cons of a drug should be laid out so that a physician or interest group knows exactly what the patient is getting and what the best course of treatment would be for the patient. All of this should be done to the best of their ability because it is never an exact science and

there are always exceptions. Pharmaceutical companies should make an effort to properly regulate dosages and indicate for what purposes the drug is being allocated, and properly educate those who are writing for it. While they would like it to be, not all drugs can universally be used by all patients, so education is crucial for patient safety and efficacy.

Pharmaceutical companies are just as culpable in the abuse of narcotics as physicians. While pharmaceutical companies make narcotics less appealing to drug seekers by making them tamper-resistant, their intentions are about the business, not the morality of why they should be doing this. Purdue Pharma and Endo Pharmaceuticals have agreed to make tamper-proof versions of the heavy narcotics, specifically OxyContin and Opana, because crushing or melting the drug releases its euphoric effects. For example OxyContin and Opana have been formulated into tablets that gel or break into large pieces when they tampered with (Thomas and Meier). While the companies use the ruse that it is for public safety, their legal battles suggest otherwise (Thomas and Meier).

Their purpose is to ban generics forms of the drug from being produced (for purposes of profit), not so that drug seekers cannot crush and snort the highly potent narcotics. These pharmaceutical companies have lobbied against Congressional legislation that would allow for

tamper-proof generics. They also want their tamper-resistant product to have a safety stamp of approval from the Food and Drug Administration that other companies would have to match. Currently, there is no distinguishing marking on the drugs that indicates they are tamper resistant. Both these drugs' patents are running out and it seems as though it is just an attempt to keep business and competition away from their product.

Another issue the preceding addresses is the generic versus brand cost versus profit margin. For most common narcotic prescriptions there are also generic brands which are generally cheaper and can be more appealing to drug seekers who look to sustain their drug habit or to sell the drugs and make a profit. While it is good that the makers of the narcotics listed above have been reformulated to help protect public safety, what if the drugs went generic with no tamper-resistant forms of protection, causing a high demand from drug seekers?

Essentially, if they are successful in their legal battles, the pharmaceutical companies will potentially increase the problem because eventually these drugs will go generic and they will be cheaper. If Big Pharma are lobbying for a ruling where generic drugs cannot be tamper-resistant and the brands are, then seekers are more likely to fill for the generic substitution. If the companies are successful in their law suits,

generic substitutions would be more deadly. If the generic is not tamper-resistant, then why would you want the brand that is if your primary purpose is to get high?

I will interject here and suggest that people who are addicted to using these substances probably do not have large financial means at their disposal, so they are going to want the cheapest "high" they can get. The addiction consumes their life, more than likely, replacing responsibilities like working or being functional in the family dynamic. For them, I would suggest the generic is what they will purchase because it is cheaper; the pharmaceutical companies do not want there to be a generic tamper-resistant equivalent, therefore, the addict is actually getting exactly what they want, which is not safe for them. By doing this, they are actually hindering their business as well as stabilizing and maintaining the growing narcotic abuse epidemic.

Given the first issue discussed above, I believe that their purpose is less patient concern but greater profit concern. They want to keep the brand on the market because it makes more money and because it is less dangerous. Brand medications are more expensive, so many people opt for the generic equivalent which is more dangerous, as will those who want to attain their "high" and sustain their addiction.

Eventually, patents run out and a generic equivalent is manufactured. This is where I believe the problem regarding patient safety is called into question. If the companies are raging legal battles in an attempt to ban generic tamper-resistant equivalents, then more patients are going to want the cheaper alternative, which will be more dangerous than its brand counterpart. In the end, the pharmaceutical companies will still lose money—i.e. profit—because once the patent expires another company will be frantically working to create the first generic equivalent. It is different if the patent is new and there is no generic available, but one must look to the future. Most medications now have, or will shortly have a generic equivalent that can be substituted. It is really only a question of time. If this is really about patient safety, then companies should be working together to help keep the medications safe for the patient. They created the tamper-proof tablet for a reason, didn't they? I believe that it was in response to an ever increasing abuse of this type of medication and as a way to diminish the possibility of getting high from these medications.

According to *The Journal of Pain*, the percentage of patients being treated at abuse clinics who had abused OxyContin fell dramatically after the introduction of the tamper-resistant tablets. Maybe if all the narcotics and their generics were like this we could see a dramatic

change in the amount of abusers and deaths related to narcotic overdose (Thomas and Meier).

Because of influence, money and power, investigations have been focused on narcotic suppliers and their consumers. There have been investigations into the financial relationships between pharmaceutical companies, pain specialists, advocacy groups, and those who set the guidelines regarding the physician's use of the drugs. The Senate Finance committee investigated this issue to clarify that physicians are given accurate information about the pros and cons of medications uncontaminated by the producer's financial interest. The Senate believes that given the increasing epidemic of narcotic abuse, someone is not relaying the risks associated with the medications to those who are ingesting them.

Overdoses, in some areas, cause more deaths than highway accidents, and the rate at which these are being prescribed has increased substantially. It is known that these drugs put patients at increased risk especially when used over long periods of time and in large doses. Narcotics can be effective when used properly and carefully; however, communication between the producers and dispensers may be muddling the line between proper use and irresponsible abuse. The relationship between the interest groups listed above could be to blame

for the surge in narcotic prescriptions. Some believe that within the relationship of the interest groups, one is exerting more influence than it should which can affect how the drugs are regulated, and how doctors view the safety of the drugs they are prescribing.

Before the 1990s, pain medications were generally used for treatment in cancer patients, or in palliative or hospice care. Pharmaceutical companies began expanding on what their approved drug uses were and expanded the use of these drugs to include treatment of chronic pain and other broader uses. Since then, the number of non-cancer related pain uses that these drugs are being dispensed for is increasing astronomically. “The percentage of opioids for non-cancer musculoskeletal pain doubled from 1980 to 2000, from 8% to 16%” (Denisco, Chandler, and Compton). With this increase, the financial ties of those interest groups mentioned above were established, cultivated, and allowed to grow. Drug companies, at this time, also began to lobby the government to change laws to make it easier to prescribe these drugs.

Marketing was another scheme that pharmaceutical companies use to promote their product and inconsequently paved the way for abuse. The makers of OxyContin caused widespread prescribing and misuse by marketing the product to general practitioners who were not

properly trained in pain management or determining drug abuse. While the company denies that this is true, several employees pleaded guilty in court to criminal charges of misleading physicians to believe that it was safe and less likely to be abused because it was long-lasting. Unfortunately, the longer lasting effect is what creates the higher high if injected, snorted, or taken in other ways than orally.

While, I feel, that the pharmaceutical companies are not entirely to blame for the surge in narcotic abuse, they do make up a large component of the blame. They know how these drugs work, yet, they still try to change laws to make it easier for people to obtain these drugs. They may not include all the pertinent information regarding the drug because they want their interest groups to want to use them and to think that they are the best for the treatment of their patients. This becomes dangerous because it is well known and documented that misleading or incomplete information directly affects the patient and puts them at an increased risk.

The pharmaceutical companies also are expanding symptoms these heavy narcotics can be used for which is creating a greater profit for their company. The more they sell, the greater the profit; however, their sale plots puts the patient at greater risk of misuse, abuse, addiction, and possibly death. The financial ties established between the

interest groups hinder the ability to address all of the pros and cons of the drugs. We all know that if the risks outweigh the benefits, then people are not going to use the product. When people do not use these products, no profit is made. Profit is what keep pharmaceutical businesses operating and to them it does not seem like a bad idea to leave out some information in order to stay in business. This is the same line of thinking that hospitals, patient satisfaction surveys, and reimbursement procedures follow.

Pharmaceutical companies should concern themselves more with patient safety because that is supposed to be the reason why they are in business; they are to create medications that help people. They should not block legislations for generics with the same tamper-resistant qualities that are known to decrease the percentage of people being treated for heavy narcotic abuse. While I understand that it takes a substantial amount of money and time to produce a drug, business should not supersede their main goal and reason for existing. Companies know that when a patent runs out, then other companies can produce generic equivalents. This reasoning is behind why I feel the pharmaceutical companies' try to block generics in order to keep their own profits and interests in mind. I understand it is a business rivaled in

competition and money, however, this is also about patient safety and a matter, literally, of life and death.

CHAPTER 8

SOME SOLUTIONS TO THE EPIDEMIC: THE GOVERNMENT

In an attempt to help rectify the situation, the U.S. federal government has enacted legislation to help limit the amount and type of narcotics that can be prescribed. Given the increasing severity of the narcotic epidemic; the government has reacted by creating legislature and establishing better ways to regulate the prescribing and dispensing of narcotics because it is a well-known fact that physicians are prescribing narcotics at an alarming rate.

Some of the most progressive steps are being taken by lawmakers to really access the patients who are on continual doses of narcotics. This requires physicians who have patients on doses of narcotics over long periods of time to refer the patient to a pain specialist when the underlying pain is not improving. The CDC has advised physicians to be cautious in prescribing narcotics given the increase in narcotic related overdoses and the demand for drugs on the streets. The Departments of Defense (DOD) and Veterans Affairs (VA) are also looking for ways to reduce the number of troops and veterans on narcotic pain medications.

The Food and Drug Administration (FDA) is also enacting limitations on narcotics, particularly Schedule II prescriptions. Doctors may be limited to what they can and cannot prescribe given the increase in the abuse of narcotics. Many drugs that are removed from the market are due to the physicians prescribing them for purposes they were not intended for—they are misusing the medications. This would require that physicians be adequately trained and educated for the product they are looking to prescribe. This would help to make sure that only those who are educated would be able to prescribe. Many deaths have been caused because the patient was not properly educated in the severity of misusing the drug. There have been documented cases of physicians prescribing heavy narcotics for patients who did not need them. For example, a patient getting a narcotic for a sprained ankle is deemed severely dangerous to the patient.

Some states, where there is an increased issue with narcotic abuse, have begun to enact new rules and legislations to help curtail the issue. New York has begun to limit what is being dispensed in public hospital emergency rooms. Under the new regulations, patients will no longer be permitted to get prescriptions for narcotics for more than three days. Heavy narcotics such as Fentanyl, Methadone, and OxyContin will not be dispensed at all, and all damaged, lost, or stolen prescriptions will

not be rewritten. These regulations would not apply to those receiving palliative care or patients with cancer pain.

This restriction is expected to help reduce the crime involved with prescription drugs, help reduce the number of overdoses, and the overall prescription drug problem in New York. This would give the physicians the support and backing they need to say “no” to a patient without repercussions stemming from an unfavorable patient satisfaction survey. This is not only in affect in New York, but also in other places where prescription drug abuse is rampant such as Utah, Florida, Washington D.C., and more. “The Appalachian states of Kentucky, Tennessee, and West Virginia were called “ground zero” for prescription drug abuse” (Devi 378).

The CDC reported that their Injury Center is working to help lessen the amount of prescription drug overdoses. They are working to improve systems to track prescriptions by enhancing the monitoring programs that track controlled substances, improve federal data systems, and link all the data to patient’s medical records. They are hoping that by tracking this information, they can begin to formulate preventative measures to help with the issue. They are looking to prevent people from going from doctor to doctor in search of narcotic scripts. While beneficial, the programs need to be able to be utilized across state

lines as a measure to prevent doctor hopping. This can also help those who really need medication to get it while preventing those who do not need it from obtaining them. This can help aid in preventing misuse and abuse of narcotics thereby lessening the amount of overdoses. They look to increase the accountability of healthcare professionals for their actions (CDC). If there are limits, then it will be much harder for people to abuse the system and narcotic medications.

One of the other problems in the menagerie of prescription drug abuse is “pill mills.” These are places where people receive copious amounts of narcotics from physicians who write in bulk for profit, and the pills are then redistributed to “vendors.”

As I explained above, physicians are being forced into writing narcotic scripts against their better judgment due to dissatisfied patient surveys, which is essentially excusing them for improperly practicing medicine. The Centers for Disease Control is hoping that their program will give the physicians adequate information to properly and effectively prescribe narcotics. They are tracking prescribing habits and daily doses of narcotics nationwide, in an attempt to identify characteristics of improper prescribing. By identifying those physicians who prescribe improperly, the CDC can then help to reduce the misuse of narcotics and overall the number of overdoses.

Not only must we be cautious of what is being prescribed, but also how to dispose of unused medications. It may not seem like a huge deal, but many people obtain medications via the trash people throw out. There should be guidelines and accessible places for disposal of these medications. Personally, I know my place of employment does this biannually through the local police department, however, this is clearly not enough. Many of these medications are from the elderly and consist of pain medications. People are unsure of where or how they should dispose of these medications. This issue is unacceptable given the rising epidemic. There should be a place where one can go to dispose of said medications as well as instructions on how to properly dispose of these medications. I believe one accepted practice is putting the medication in the garbage with used cat litter or coffee grounds. I am unsure whether this is common knowledge, but it should be.

CHAPTER 9

SOLUTIONS TO THE EPIDEMIC: PHYSICIANS

I assert that while the government is helping to rectify the situation, I am also obliged to say that physicians need to be more reluctant to write narcotic prescriptions. For physicians, I offer this plausible solution: physicians should make a conscientious effort to use the software provided to check whether patients are emergency room hoping. The physician should be educated on the importance of utilizing the software and should not be so quick to write prescriptions. They should be supported by their hospital or emergency care employer, not scolded for saying "no" to an addict. Writing scripts should not be about taking the easy way out; especially when the patient could overdose and die or cause someone else to die. Employers should monitor the amount of narcotics being prescribed as well as the physicians who are prescribing them. If there are any "red flags," they should be monitored, addressed, and handled appropriately.

Physicians should be responsible and mindful not to prescribe narcotics to patients who show clear signs of addiction or in situations where the narcotic is not appropriate for their ailment. Even though the

technology is not fully operational as yet, an effort should be made to educate physicians on how to access true dental pain, especially since this is the most common complaint that leads to the writing of prescriptions for narcotics.

Education seems to be the primary driving force in rectifying the problem at the prescribing level because this is the fundamental or rudimentary base that keeps the problem continuing. Only when we educate the physicians, and they practice what they learn, will we be able to address the issue and begin to fix it.

CHAPTER 10

SOLUTIONS FOR THE EPIDEMIC: HOSPITALS AND ADMINISTRATION

For hospitals and administrators, I provide the following solution: be mindful of the fact that there is an increasing narcotics problem that it is being enabled and sustained through their establishment. They should be more liberal with physicians regarding those who choose not to prescribe this class of drug; after all they were educated by a medical school to be able to prescribe properly. Physicians should not be reprimanded for picking out drug seekers and not prescribing narcotics for them. If they are not praised for ascertaining the right diagnosis and medicating or, in the case of seekers, not medicating for it, then the ongoing narcotics problem will only continue and possibly worsen. Prescribing has become a matter of everyone who wants narcotics gets narcotics, which is exactly the opposite of what physicians are trained to do. They are trained to diagnose and treat patients through writing scripts when warranted. Their profession is not about prescribing narcotics so their patient can develop a drug habit that the physician knows could kill them. Again, by forcing physicians to accommodate the

patient in their position of power due to the surveys, the hospitals and emergency care centers are undermining the professionalism and dignity of the medical profession. The hospital should be maintained through honest means, not based solely on profit determined by random patient dissatisfaction surveys. As I have expressed previously, I believe patient satisfaction surveys do have their benefits, there is no denying this, but their true purpose or intention is not to enable a drug ridden society.

CHAPTER 11

CONCLUDING REMARKS

Overall, I have deduced from my research that the prescription drug abuse problem is fueled and sustained by healthcare systems, physicians, and pharmaceutical companies. My thesis was: Prescription drug abuse is propelled by and sustained through three factors: the demand on physicians through patient satisfaction surveys, inadequate or insufficient technologies available to physicians coupled with demands on their time, and the questionable morality of a profit-based pharmaceutical industry in their marketing and legal battles. I believe I have substantiated my claim that the issue is tri-fold. If the issue is allowed to continue due to patient satisfaction surveys pushing for physicians to just prescribe, inadequate or insufficient technologies for physicians to utilize, and the profit based mentalities of the pharmaceutical companies and hospitals, all of this coupled together will keep prescription drug abuse on a continuum until the system is changed by readily reducing available narcotic medications to millions. The only way to get to the root of the issue and not just put a bandage on the situation: is to educate each contributing party about the severity of

the issue at hand and their part in sustaining the problem. Next is to make the parties to understand their accountability for their participation and take responsibility for modifying their actions to rectify the problem. Once this is addressed and only after that can an overall change happen to the system.

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